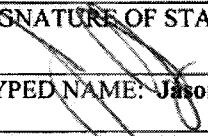
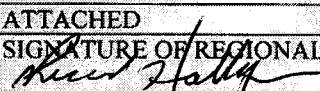


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-65-A	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE December 1, 2009	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447.204		7. FEDERAL BUDGET IMPACT: a. FFY 12/1/09 – 9/30/10 \$42,856 b. FFY 10/1/10 – 9/30/11 \$ 47,436	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages 1(e)(1), 1(e)(2), 1(e)(2.1), 1(e)(3), 1(f), 1(g), 1(g)(1), 1(h), 1(h)(1), 1(h)(2), 1(i), 1(j), 1(j)(i), 1(l), 1(l)(i), 1(l)(ii)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B: Pages 1(e)(1), 1(e)(2), 1(e)(3), 1(f), 1(g), 1(h), 1(i), 1(j), 1(j)(i), 1(l), 1(l)(i)	
10. SUBJECT OF AMENDMENT: Revisions to Hospital Based APGs FMAP: 61.59% for 12/1/09 – 12/31/10; 58.77% for 1/1/11 – 3/31/11; 56.88% for 4/1/11 – 6/30/11; 50% 7/1/11 and after			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Bureau of HCRA Oper & Financial Analysis 99 Washington Ave – One Commerce Plaza Suite 810 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: January 3, 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: February 6, 2013	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: December 1, 2009		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Ricardo Holligan		22. TITLE: Acting Associate Regional Administrator Division of Medicaid and State Operations	
23. REMARKS:			